Dear Parent/ Legal Guardian,

The high school your student is enrolled in provides expanded medical services, such as care for acute illnesses, primary prevention and emergency health care, and treatment for chronic conditions. The goal of the program is to improve the overall health status of students through shared school-based and community resources helping to assure that students are healthy in the classroom and ready to learn.

The School-Based Health Clinics Program is a partnership between the Florida Department of Health in Pinellas County, Juvenile Welfare Board (JWB), Pinellas County School System, Suncoast Center, Inc., and the administrations at Boca Ciega, Gibbs, Northeast, Largo and Pinellas Park High School.

The expanded services are funded by JWB through local taxes. As part of the funding, the Florida Department of Health in Pinellas County is required to collect personally identifiable information on students for program accountability and quality improvement activities.

This packet of material contains information on the program as well as forms for enrolling your student in the clinic.

If you would like your student to receive additional health services **AT NO COST**, please complete and sign the following forms and return them to the school clinic as soon as possible:

Consent for School-Based Health Clinic Services – complete the entire form and sign *Section 3* and, if your student has Medicaid, check the box in *Section 4* and sign the bottom.

Adolescent Health History – complete the entire form.

Initiation of Services – complete and sign *Part VII.*

Interagency Consent for Services and Release of Information – complete and sign.

Notice of Privacy Practices – keep for your records.

If you have any questions about these forms or services, please contact the clinic at your child's school:

Boca Ciega High School Clinic: (727) 893-2780 ext. 2026
Gibbs High School Clinic: (727) 893-5452 ext. 2026
Largo High School Clinic: (727) 588-3758 ext. 2026
Northeast High School Clinic: (727) 570-3138 ext. 2325
Pinellas Park High School Clinic: (727) 538-7410 ext. 2026

FLORIDA DEPARTMENT OF HEALTH

Consent for School-Based Health Clinic Services

## 1. Student information (please print clearly)

Last Name: _____ Date of Birth: _____

First Name: _____ School: _____

Middle Name: _____ Grade: _____

Suffix (Jr., Sr., II, III, etc.): _____ Social Security #: _____

## 2. Services Available to High School Students at NO Cost:

Please check any services we **cannot** provide to your child.

- ☐ School/Sports Physicals
- ☐ Immunizations
- ☐ Lab Tests (e.g. throat, urine cultures)
- ☐ Care For Minor Illness & Injuries
- ☐ Administer Over the Counter Medications (e.g. Tylenol, Ibuprofen, Tums)
- ☐ Social, Emotional, and Mental Health Counseling

**Comments:**

## 3. Agreement for Student Services

***Please read carefully and sign:***

I do hereby give my consent for the above named student to receive services at the Florida Department of Health School-Based Clinic. All services listed above that have not been checked will be available to my child. I further understand that all services authorized by myself will be available at no cost.

**Please check one:** ☐ **Parent** ☐ **Legal Guardian** ☐ **Student (if 18 or older)**

Print Name: _____ Signature: _____ Date: _____

### The Following Questions are for Data Gathering Purposes Only

1. Is your child covered by Private Insurance? ☐ Yes ☐ No
2. Is your child covered by Healthy Kids? ☐ Yes ☐ No
3. I am aware of Florida Kid Care program and I know how to apply for it. ☐ Yes ☐ No*

*If you answered **no** to question #3, contact Florida KidCare at 1-888-540-5437 Monday – Friday, 7:30 am – 7:30 pm (ET).

## 4. Medicaid Coverage Consent

Is your child covered by Medicaid? ☐ Yes ☐ No (If Yes, please continue. If No, please skip the rest of Section 4 below.)

### State of Florida Consent for Billing Medicaid

Although all school-based clinic services are available at no cost to you, the Florida Department of Health does receive partial financial assistance by billing Medicaid for students with Medicaid coverage. If your child is indeed covered by Medicaid, please sign the following consent.

I hereby assign the Florida Department of Health all benefits provided under the Medicaid health care plan. The amount of such benefits shall not exceed the medical charges set forth by the Pinellas County Board of Commissioners. All payments under this paragraph are to be made to the Florida Department of Health. I further authorize the Florida Department of Health at 205 Dr. M. L. King Jr. Street North, St. Petersburg, FL 33701 and any physician or healthcare provider examining or treating my child to release to any third party for any medical, psychiatric/psychological, alcohol/drug abuse, sexually transmitted disease, tuberculosis, AIDS, HIV, abuse or case management information including information received from other health care providers, concerning diagnosis and treatment for its use in determining a claim for such diagnosis or treatment. This may include any and all information pertaining to payment.

**Please check one:** ☐ **Parent** ☐ **Legal Guardian** ☐ **Student (if 18 or older)**

Print Name: _____ Signature: _____ Date: _____

# Adolescent Health History
# Confidential

**Name:** _____ _____ _____ **Date:** _____

Last First Middle

**Date of Birth:** ____/____/____ **Sex:** ☐ Male ☐ Female **Age:** _____ **Race:** _____ **Gender:** _____

**Ethnicity:** ☐ Hispanic, Latino, or Spanish Origin: _____

☐ Non-Hispanic

**Primary language(s) spoken:** _____

**Twin:** ☐ Yes ☐ No

**Number of Minor Children (under 18):** _____

**Number of Adults (18 or older):** _____

**Annual Household income (before taxes):** _____

**Who do you live with?** _____

## Medical History

| | |
|---|---|
| **Does your Child have Established Primary Care?** Y N | **Does your child have allergies?** |
| **Name of Personal/ Family Physician:** | **Allergic Reaction(s):** |
| **Date of last visit with Physician:**<br>**Last Physical:** | **Does your child carry epi pen or inhaler?** Y N |
| **Does your child have a Dentist?** Y N | **Is your child taking any Medication?** Y N<br>Please list: |
| **Date of last dental exam:** | |

**Please answer all questions below, for responses with yes include any additional information and indicate the age it was diagnosed:**

| | Yes | No | Age | | Yes | No | Age | | Yes | No | Age |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ADHD | ☐ | ☐ | | Mononucleosis | ☐ | ☐ | | Victim of physical or sexual abuse | ☐ | ☐ | |
| Anemia or bleeding disorders | ☐ | ☐ | | Nosebleeds | ☐ | ☐ | | **Family History:** | | | Relationship |
| Asthma | ☐ | ☐ | | Pneumonia | ☐ | ☐ | | ADHD | ☐ | ☐ | |
| Autism spectrum | ☐ | ☐ | | Prediabetes | ☐ | ☐ | | Asthma | ☐ | ☐ | |
| Dental problems/cavities | ☐ | ☐ | | Premature birth | ☐ | ☐ | | Cancer | ☐ | ☐ | |
| Diabetes Type 1 or 2 | ☐ | ☐ | | Scoliosis/orthopedic problems | ☐ | ☐ | | Depression | ☐ | ☐ | |
| Eating disorder or concerns | ☐ | ☐ | | Seizures | ☐ | ☐ | | Diabetes | ☐ | ☐ | |
| Fainting spells | ☐ | ☐ | | Severe acne/skin problem | ☐ | ☐ | | Heart Disease | ☐ | ☐ | |
| Headaches | ☐ | ☐ | | Severe menstrual cramps | ☐ | ☐ | | High Blood Pressure | ☐ | ☐ | |
| High blood pressure or heart disease | ☐ | ☐ | | Sickle cell disease | ☐ | ☐ | | High Cholesterol | ☐ | ☐ | |
| High cholesterol | ☐ | ☐ | | Single kidney | ☐ | ☐ | | Kidney Disease | ☐ | ☐ | |
| Hospitalizations | ☐ | ☐ | | School academic or social concerns | ☐ | ☐ | | Does anyone smoke in the house? | ☐ | ☐ | |
| Kidney or bladder problems | ☐ | ☐ | | Snoring or sleep problem | ☐ | ☐ | | If either biological parent is deceased if yes, cause: | ☐ | ☐ | |
| Menstrual irregularities | ☐ | ☐ | | Stomach problems | ☐ | ☐ | | Other: | ☐ | ☐ | |
| Mental Health | ☐ | ☐ | | Surgeries | ☐ | ☐ | | Other: | ☐ | ☐ | |
| Migraines/headaches | ☐ | ☐ | | Testes | ☐ | ☐ | | Other: | ☐ | ☐ | |

**If yes, please describe:**

# INITIATION OF SERVICES

**PART I** **CLIENT-PROVIDER RELATIONSHIP CONSENT**

Client Name: _____

Name of Agency: **Florida Department of Health - Pinellas County**

Agency Address: **205 Dr. Martin Luther King Jr. St. N., St. Petersburg, FL 33701**

I consent to entering into a client-provider relationship. I authorize Department of Health staff and their representatives to render routine health care. I understand routine health care is confidential and voluntary and may involve medical visits including obtaining medical history, assessment, examination, administration of medication, laboratory tests and/or minor procedures. I may discontinue this relationship at any time.

**PART II** **DISCLOSURE OF INFORMATION CONSENT** (treatment, payment or healthcare operations purposes only)

I consent to the use and disclosure of my health information; including medical, dental, HIV/AIDS, STD, TB, substance abuse prevention, psychiatric/psychological, and case management; for treatment, payment and health care operations.

**PART III** **MEDICARE PATIENT CERTIFICATION, AUTHORIZATION TO RELEASE, AND PAYMENT REQUEST** (Only applies to Medicare Clients)

As Client/Representative signed below, I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the above agency to release my health information to the Social Security Administration or its intermediaries/carriers for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician's services to the above-named agency and authorize it to submit a claim to Medicare for payment.

**PART IV** **ASSIGNMENT OF BENEFITS** (Only applies to Third Party Payers)

As Client /Representative signed below, I assign to the above-named agency all benefits provided under any health care plan or medical expense policy. The amount of such benefits shall not exceed the medical charges set forth by the approved fee schedule. All payments under this paragraph are to be made to above agency. I am personally responsible for charges not covered by this assignment.

**PART V** **COLLECTION, USE OR RELEASE OF SOCIAL SECURITY NUMBER**

(This notice is provided pursuant to Section 119.071(5)(a), Florida Statutes.)

For health care programs, the Florida Department of Health may collect your social security number for identification and billing purposes, as authorized by subsections 119.071(5)(a)2.a. and 119.071(5)(a)6., Florida Statutes. By signing below, I consent to the collection, use or disclosure of my social security number for identification and billing purposes only. It will not be used for any other purpose. I understand that the collection of social security numbers by the Florida Department of Health is imperative for the performance of duties and responsibilities as prescribed by law.

**PART VI** **MY SIGNATURE BELOW VERIFIES THE ABOVE INFORMATION AND RECEIPT OF THE NOTICE OF PRIVACY RIGHTS**

_____ _____ _____

Client/Representative Signature | Self or Representative's Relationship to Client | Date

_____ _____

Witness (optional) | Date

**PART VII** **WITHDRAWAL OF CONSENT**

I, _____ WITHDRAW THIS CONSENT, effective _____

Client/Representative Signature | Date

_____ _____

Witness (optional) | Date

Client Name: _____

ID#: _____

Original to file; Copy to client

DOB: _____

DH 3204-SSG-09-2019

# FORMULARIO DE INICIO DE LOS SERVICIOS

**PARTE I** **CONSENTIMIENTO PARA EL INICIO DE LA RELACIÓN ENTRE CLIENTE Y PROVEEDOR**

Nombre del cliente: _____

Nombre de la agencia: **Florida Department of Health - Pinellas County**

Dirección de la agencia: **205 Dr. Martin Luther King Jr. St. N., St. Petersburg, FL 33701**

Doy mi consentimiento para iniciar la relación entre cliente y proveedor. Autorizo al personal del Departamento de Salud (Department of Health) y a sus representantes a darme atención médica de rutina. Entiendo que la atención médica de rutina es confidencial y voluntaria. Esto puede incluir visitas médicas en la que se obtenga mi historia médica, me hagan exámenes médicos, me administren medicamentos o me hagan análisis de laboratorio o procedimientos menores. Puedo terminar con esta relación en cualquier momento.

**PARTE II** **CONSENTIMIENTO PARA REVELAR INFORMACIÓN** (solo para propósitos de tratamiento, pago u operaciones de atención médica).

Para propósitos de tratamiento, pago u operaciones de atención médica, doy mi consentimiento para que se use y se revele mi información de salud, que incluye información médica, dental, sobre VIH/sida, STD (enfermedades de transmisión sexual), TB (tuberculosis) y prevención de trastornos por abuso de sustancias; información psiquiátrica o psicológica y de administración de casos.

**PARTE III** **CERTIFICACIÓN, AUTORIZACIÓN PARA REVELAR INFORMACIÓN Y SOLICITUD DE PAGO DEL PACIENTE DE MEDICARE** (solo corresponde para clientes que tengan Medicare).

Yo, el cliente/representante que firma abajo, certifico que la información que di en la solicitud de pago en conformidad con el Título XVIII de la Ley de Seguro Social (Social Security Act) es correcta. Autorizo a la agencia indicada arriba a entregar mi información médica a la Administración del Seguro Social (Social Security Administration) o sus intermediarios o compañías aseguradoras para este o cualquier otro reclamo relacionado con Medicare. Solicito que se haga el pago de los beneficios autorizados en mi nombre. Cedo los beneficios pagaderos por servicios médicos a la agencia mencionada arriba y la autorizo a presentar el reclamo ante Medicare para el pago correspondiente.

**PARTE IV** **CESIÓN DE LOS BENEFICIOS** (solo corresponde para pagadores externos).

Yo, el cliente/representante que firma abajo, cedo a la agencia mencionada arriba todos los beneficios que reciba de cualquier plan de atención médica o póliza de gastos médicos. La cantidad de tales beneficios no debe superar los cargos médicos detallados en la lista de tarifas aprobadas. Todos los pagos cubiertos en este párrafo deben hacerse a la agencia indicada arriba. Entiendo que soy personalmente responsable de los gastos que no cubra esta cesión.

**PARTE V** **RECOPILACIÓN, USO O REVELACIÓN DEL NÚMERO DEL SEGURO SOCIAL**

(Este aviso se entrega de conformidad con la Sección 119.071(5)(a) de los Estatutos de Florida).

Para los programas de atención médica, el Departamento de Salud de Florida puede recopilar su número del Seguro Social con fines de identificación y facturación, según se autoriza en las subsecciones 119.071(5)(a)2.a y 119.071(5)(a)6 de los Estatutos de Florida. Al firmar abajo, doy mi consentimiento para que se recopile, se use o se revele mi número del seguro social únicamente con fines de identificación y facturación. No podrá usarse con ningún otro fin. Entiendo que el Departamento de Salud de Florida debe recopilar los números del seguro social para cumplir las obligaciones y las responsabilidades que exige la ley.

**PARTE VI** **SI FIRMO ABAJO, CERTIFICO QUE LA INFORMACIÓN DE ARRIBA ES CORRECTA Y CONFIRMO QUE RECIBÍ EL AVISO DE LOS DERECHOS DE PRIVACIDAD**

_____ _____ _____

Firma del cliente/representante | Indicar la relación del representante con el cliente o si este actúa en nombre propio | Fecha

_____ _____

Testigo (opcional) | Fecha

**PARTE VII** **RETIRO DEL CONSENTIMIENTO**

Yo,_____, RETIRO ESTE CONSENTIMIENTO a partir del ____

.

Firma del cliente/representante Fecha

_____ _____

Testigo (opcional) Fecha

Nombre del cliente: _____

N.º de id.: _____

Original: para archivar; copia: para el cliente Fecha de nacimiento: _____

# INTERAGENCY CONSENT
# FOR SERVICES AND RELEASE OF INFORMATION

Student Name: _____ Date of Birth: _____

Address: _____ Apartment/Unit/Lot: _____

City: _____ Zip Code: _____ Telephone Number: _____

School: ☐ Boca Ciega, Northeast, Gibbs, Pinellas Park, Largo HS ☐ Other School: _____

***Check the appropriate box then read and sign the Consent Section:***

☐ As the parent/legal guardian of the above-named student, I, _____, consent to the student receiving services from the *Department of Health in Pinellas County* and *Suncoast Center, Inc.*

☐ I, the above-named student, consent and agree to receive services from the *Florida Department of Health* and *Suncoast Center, Inc.*

The expanded services at the school are funded by the Juvenile Welfare Board (JWB) through local taxes. As part of the funding, the *Department of Health in Pinellas* and *Suncoast Center, Inc.* are required to collect additional personally identifiable information on the student for program accountability and quality improvement activities. However, the student will not be denied the basic school health services if you choose not to sign the form. Once the information is received by JWB it is encrypted and de-identified to protect parental and student privacy rights (See JWB Written Statement of Purpose(s) for Collection of Confidential Information form).

***Consent Section***

I consent to my minor participating in online or paper surveys that will be used for program improvements and enhancements.

I authorize the *Florida Department of Health in Pinellas County and Suncoast Center, Inc.* to release to and receive from the *School Board of Pinellas County* medical/education records (the "Records"). I understand that such Records may contain health information pertaining to psychiatric, drug and/or alcohol diagnosis and treatment, HIV/AIDS as well as educational records, immunization records, suspensions/office referral data, attendance data, referrals to student service teams, and written and verbal communication with school staff related to mental health intervention.

I authorize the *Florida Department of Health in Pinellas County, Suncoast Center, Inc.*, and *School Board of Pinellas County* to release personally identifiable student information, such as student social security number, name, address, date of birth, household number, household living arrangement (parents, single parent, grandparent etc.), and free and reduced lunch information to JWB.

I also authorize the *Florida Department of Health in Pinellas County, Suncoast Center, Inc.,* and *School Board of Pinellas County* to release protected health information and all information pertaining to treatment received at the school clinic, home or anywhere else where I am receiving treatment from these providers and any and all other medical information in their control to JWB. I further authorize the *Florida Department of Health in Pinellas County*, *Suncoast Center, Inc.,* and *School Board of Pinellas County* to release records may which may contain health information pertaining to psychiatric, drug and/or alcohol diagnosis and treatment, HIV/AIDS as well as educational records, immunization records, suspensions/office referral data, attendance data, referrals to student service teams, and written and verbal communication with school staff related to mental health intervention to JWB.

I understand that the Records will be released and received for the purpose of treatment, payment/reimbursement, quality improvement and research activities.

I understand this consent is in place while the above named student is enrolled in one of the above named Pinellas County Schools. This consent will terminate when the above named student is no longer enrolled in or graduates from one of the above named Pinellas County Schools, except for the purpose of research and compliance reviews. I understand I have the right to revoke this consent at any time. If I revoke this consent, it must be in writing and be presented to the health clinic at the above named school. I understand that if I revoke my consent that it will not apply to any information already released and/or used as a result of my prior consent.

I release the School Board of Pinellas County, Florida Department of Health in Pinellas County, Suncoast Center, Inc., and the Juvenile Welfare Board of Pinellas County, their officers, agents, and employees, from liability for the release of information in accordance with this consent.

_____ _____ _____

Signature of parent/guardian or adult student (over 18 years old) Date Relationship to Student

_____ _____

Signature of Witness Date

# NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

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## USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

Protected health information includes demographic and medical information that concerns the past, present, or future physical or mental health of an individual. Demographic information could include your name, address, telephone number, social security number and any other means of identifying you as a specific person. Protected health information contains specific information that identifies a person or can be used to identify a person.

Protected health information is health information created or received by a health care provider, health plan, employer, or health care clearinghouse. The Department of Health can act as each of the above business types. This medical information is used by the Department of Health in many ways while performing normal business activities.

Your protected health information may be used or disclosed by the Department of Health for purposes of treatment, payment, and health care operations. *Health care professionals use medical information in the clinics or hospital to take care of you. Your protected health information may be shared, with or without your consent, with another health care provider for purposes of your treatment. The Department of Health may use or disclose your health information for case management and services. The Department of Health clinic or hospital may send the medical information to insurance companies, Medicaid, or community agencies to pay for the services provided you.*

Your information may be used by certain department personnel to improve the department's health care operations. The department also may send you appointment reminders, information about treatment options or other health-related benefits and services.

Some protected health information can be disclosed without your written authorization as allowed by law. Those circumstances include:

- Reporting abuse of children, adults, or disabled persons.
- Investigations related to a missing child.
- Internal investigations and audits by the department's divisions, bureaus, and offices.
- Investigations and audits by the state's Inspector General and Auditor General, and the legislature's Office of Program Policy Analysis and Government Accountability.
- Public health purposes, including vital statistics, disease reporting, public health surveillance, investigations, interventions, and regulation of health professionals.
- District medical examiner investigations;

- Research approved by the department.
- Court orders, warrants, or subpoenas;
- Law enforcement purposes, administrative investigations, and judicial and administrative proceedings.

Other uses and disclosures of your protected health information by the department will require your written authorization. These uses and disclosures may be for marketing and for research purposes, certain uses and disclosure of psychotherapist notes, and the sale of protected health information resulting in remuneration to the Department of Health.

This authorization will have an expiration date that can be revoked by you in writing.

## INDIVIDUAL RIGHTS

You have the right to request the Department of Health to restrict the use and disclosure of your protected health information to carry out treatment, payment, or health care operations. You may also limit disclosures to individuals involved with your care. The department is not required to agree to any restriction.

You have the right to be assured that your information will be kept confidential. The Department of Health will make contact with you in the manner and at the address or phone number you select. You may be asked to put your request in writing. If you are responsible to pay for services, you may provide an address other than your residence where you can receive mail and where we may contact you.

You have the right to inspect and receive a copy of your protected health information that is maintained by the Department of Health within 30 days of the Department's receipt of your request.to obtain a copy of your protected health information. You must complete the Department's Authorization to Disclosure Confidential Information form and submit the request to the county health department or Children's Medical Services office. If there are delays in getting you the information, you will be told the reason for the delay and the anticipated date when you will receive your information.

Your inspection of information will be supervised at an appointed time and place. You may be denied access as specified by law.

If you choose to receive a copy of your protected health information, you have the right to receive the information in the form or format you request. If the Department cannot produce it in that form or format, it will give you the information in a readable hard copy form or another form or format that you and the Department agree to.

The Department cannot give you access to psychotherapy notes or certain information being used in a legal proceeding. Records are maintained for specified periods of time in accordance with the law. If your request covers information beyond that time the Department is required to keep the record, the information may no longer be available.

If access is denied, you have the right to request a review by a licensed health care professional who was not involved in the decision to deny access. This licensed health care professional will be designated by the department.

You have the right to correct your protected health information. Your request to correct your protected health information must be in writing and provide a reason to support your requested correction. The Department of Health may deny your request, in whole or part, if it finds the protected health information:

- Was not created by the department.
- Is not protected health information.
- Is by law not available for your inspection.
- Is accurate and complete.

If your correction is accepted, the department will make the correction and tell you and others who need to know about the correction. If your request is denied, you may send a letter detailing the reason you disagree with the decision. The department may respond to your letter in writing. You also may file a complaint, as described below in the section titled Complaints.

You have the right to receive a summary of certain disclosures the Department of Health may have made of your protected health information. This summary does not include:

- Disclosures made to you.
- Disclosures to individuals involved with your care.
- Disclosures authorized by you.
- Disclosures made to carry out treatment, payment, and health care operations.
- Disclosures for public health.
- Disclosures to health professional regulatory purposes.
- Disclosures to report abuse of children, adults, or disabled.
- Disclosures prior to April 14, 2003.

This summary does include disclosures made for:

- Purposes of research, other than those you authorized in writing.
- Responses to court orders, subpoenas, or warrants.

You may request a summary for not more than a 6 year period from the date of your request.

If you received this Notice of Privacy Practices electronically, you have the right to a paper copy upon request.

The Department of Health may mail or call you with health care appointment reminders.

## DEPARTMENT OF HEALTH DUTIES

The Department of Health is required by law to maintain the privacy of your protected health information. This Notice of Privacy Practices tells you how your protected health information may be used and how the department keeps your information private and confidential. This notice explains the legal duties and practices relating to your protected health information. The department has the responsibility to notify you following a breach of your unsecured protected health information.

As part of the department's legal duties this Notice of Privacy Practices must be given to you. The department is required to follow the terms of the Notice of Privacy Practices currently in effect.

The Department of Health may change the terms of its notice. The change, if made, will be effective for all protected health information that it maintains. New or revised notices of privacy practices will be posted on the Department of Health website at http://www.floridahealth.gov/about-the-department-of-health/about-us/patient-rights-and-safety/hipaa/index.html and will be available by email and at all Department of Health buildings. Also available are additional documents that further explain your rights to inspect and copy and amend your protected health information.

## COMPLAINTS

If you believe your privacy health rights have been violated, you may file a complaint with the: Department of Health's Inspector General at 4052 Bald Cypress Way, BIN A03/ Tallahassee, FL 32399-1704/ telephone 850-245-4141 and with the Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue, S.W./ Washington, D.C. 20201/ telephone 202-619-0257 or toll free 877-696-6775.

The complaint must be in writing, describe the acts or omissions that you believe violate your privacy rights, and be filed within 180 days of when you knew or should have known that the act or omission occurred. The Department of Health will not retaliate against you for filing a complaint.

## FOR FURTHER INFORMATION

Requests for further information about the matters covered by this notice may be directed to the person who gave you the notice, to the director or administrator of the Department of Health facility where you received the notice, or to the Department of Health's Inspector General at 4052 Bald Cypress Way, BIN A03/ Tallahassee, FL 32399-1704/ telephone 850-245-4141.

## EFFECTIVE DATE

This Notice of Privacy Practices is effective beginning July 1, 2013, and shall be in effect until a new Notice of Privacy Practices is approved and posted.

## REFERENCES

"Standards for the Privacy of Individually Identifiable Health Information; Final Rule." 45 CFR Parts 160 through 164. *Federal Register* 65, no. 250 (December 28, 2000).
"Standards for the Privacy of Individually Identifiable Health Information; Final Rule" 45 CFR Part 160 through 164. *Federal Register*, Volume 67 (August 14, 2002).

HHS, Modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules under the Health Information Technology for Economic and Clinical Health Act and the Genetic Information and Nondiscrimination Act; Other Modifications to the HIPAA Rules, 78 Fed. Reg. 5566 (Jan. 25, 2013).